STROUDWATER

THE ROAD TO CLOSURE: KEY WARNING SIGNS AND EARLY INTERVENTIONS

June 2025

Jeff Sommer, Managing Director

Julie Georgoff, Consultant

MEET THE SPEAKERS

Jeffrey Sommer, MPP

Managing Director

jsommer@stroudwater.com
207.221.8255

Julie Georgoff

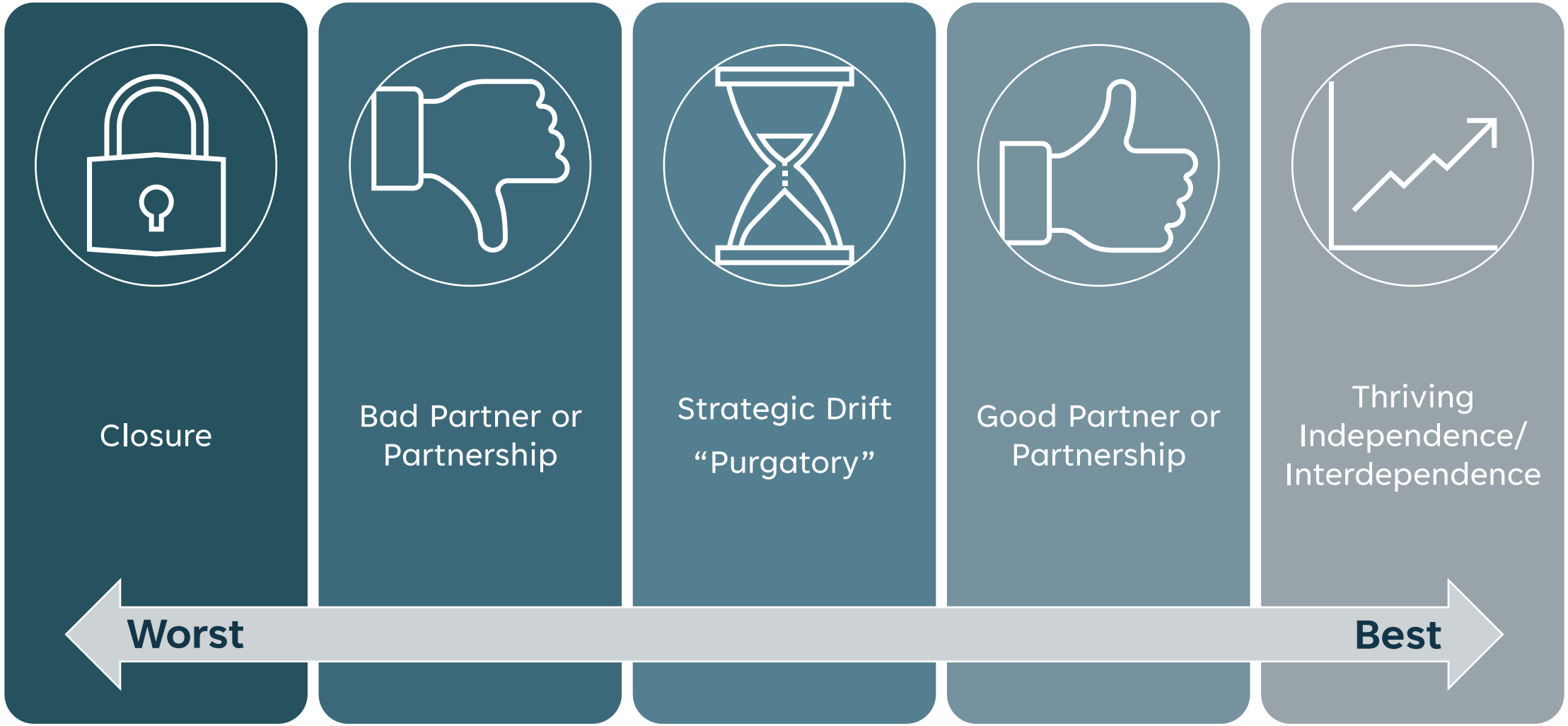
Consultant

jgeorgoff@stroudwater.com
207.221.8273

Stroudwater is a leading national healthcare consulting firm specializing in mission-critical strategic, operational, and financial opportunities for healthcare leaders' most pressing challenges

STRATEGIC CONTEXT

COMMON OUTCOMES FOR RURAL HOSPITALS



90%+/- of hospitals are within these three options

POLLING QUESTION

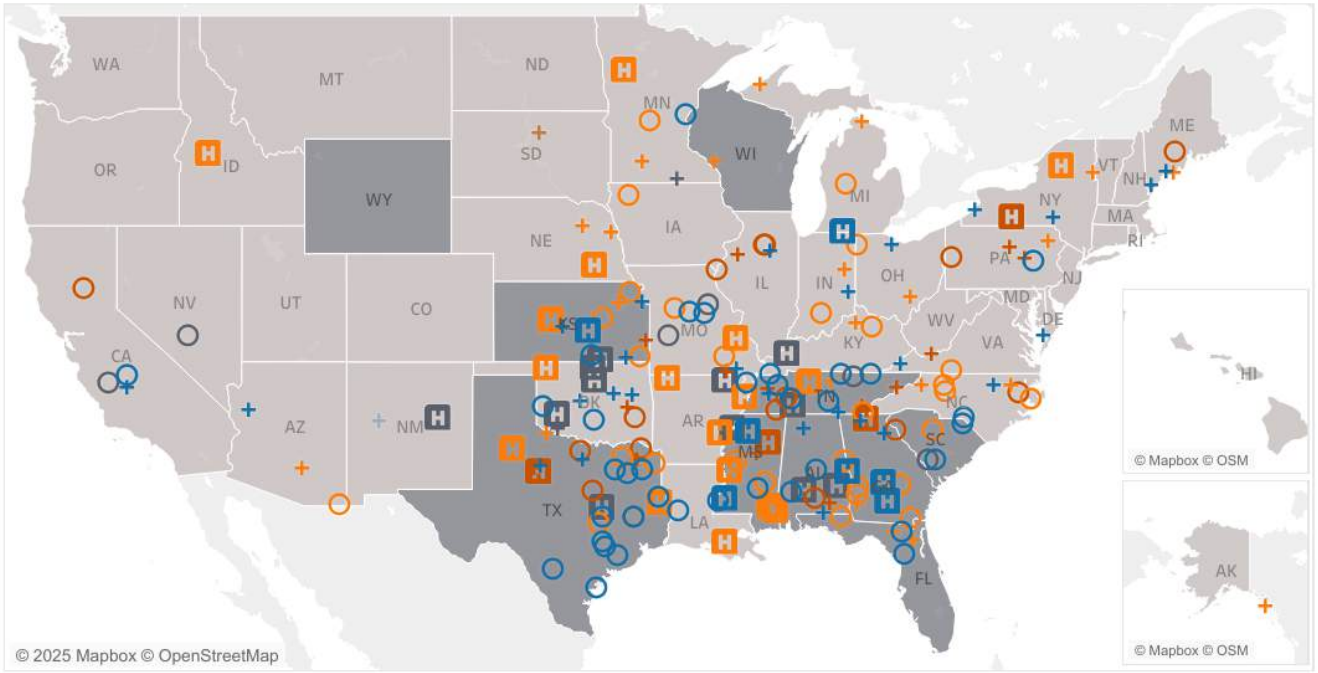
How would you describe the current state of your hospital?

a) Thriving Independence/Interdependence
b) Good partnership
c) Strategic “drift” or purgatory
d) Bad partnership
e) Risk of closure

RURAL HOSPITAL CLOSURES SINCE 2010

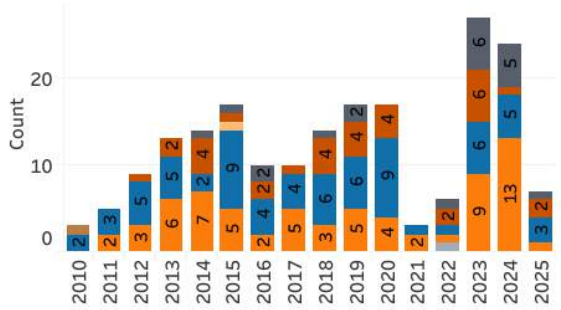
196 Closed or Converted Rural Hospitals

There have been 196 Rural Hospital closures or conversions since 2010 and 239 since 2005, these numbers include **forty (40) REH Conversions since 2023**



Year	Hospital Name
2025	Northern Light Inland Hospital-ME
	Lawrence Medical Center-AL
	Mid Coast Medical Center - Trinity-TX
	REH- Ira Davenport Memorial Hospital-NY
	REH- J Paul Jones Hospital-AL
	REH- Cascade Medical Center-ID
	Valley Community Hospital-OK
2024	REH- EAMC - Lanier-AL
	REH- Wayne Medical Center-TN
	REH- Clifton-Fine Hospital-NY
	REH- Progressive Health Group of Houston..

ST	Count
TX	27
TN	17
KS	12
OK	12
AL	11
GA	11
MO	11
MS	11
NC	8
AR	5
FL	5
MN	5
NY	5
PA	5
CA	4
IL	4
KY	4
ME	4
MI	4
SC	4
AZ	3
IN	3
NE	3
OH	3
IA	2
LA	2
NM	2
VA	2
AK	1
ID	1
MD	1
NV	1
SD	1
WI	1
WV	1



Year	Prospective Payment System	Critical Access Hospital	Medicare Dependent Hospital	Sole Community Hospital	IHS	Re-based Sole Community Hospital	Rural Referral Center	Total
2010	2					1		3
2011	3	2						5
2012	5	3	1					9
2013	5	6	2					13
2014	2	7	4	1				14
2015	9	5	1	1			1	17
2016	4	2	2	2				10
2017	4	5	1					10
2018	6	3	4	1				14
2019	6	5	4	2				17
2020	9	4	4					17
2021	1	2						3
2022	1	1	2	1	1			6
2023	6	9	6	6				27
2024	5	13	1	5				24
2025	3	1	2	1				7
Total	71	68	34	20	1	1	1	196

Medicare Payment Type
- Prospective Payment System
- Critical Access Hospital
- Medicare Dependent Hospital
- Sole Community Hospital
- Re-based Sole Community Hospital
- Rural Referral Center
- IHS

Current Status
- REH
- Complete Closure
- Convert to Other

Current Status of Medicaid Expansion Decision
- Adopted the Medicaid Expansion
- Not Adopting the Medicaid Expansion at this Time

Updated:6/10/2025

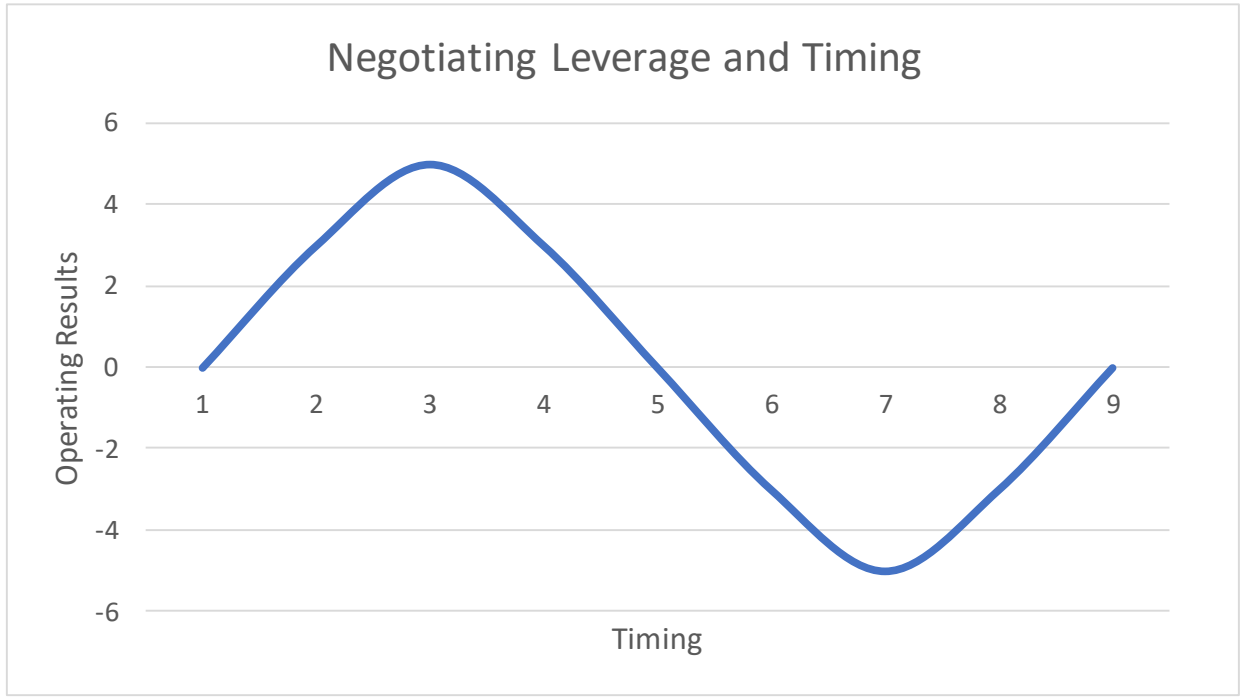
Sources: The North Carolina Rural Health Research Program (NC RHRP) at the Cecil G. Sheps Center for Health Services Research & kff.org

STROUDWATER

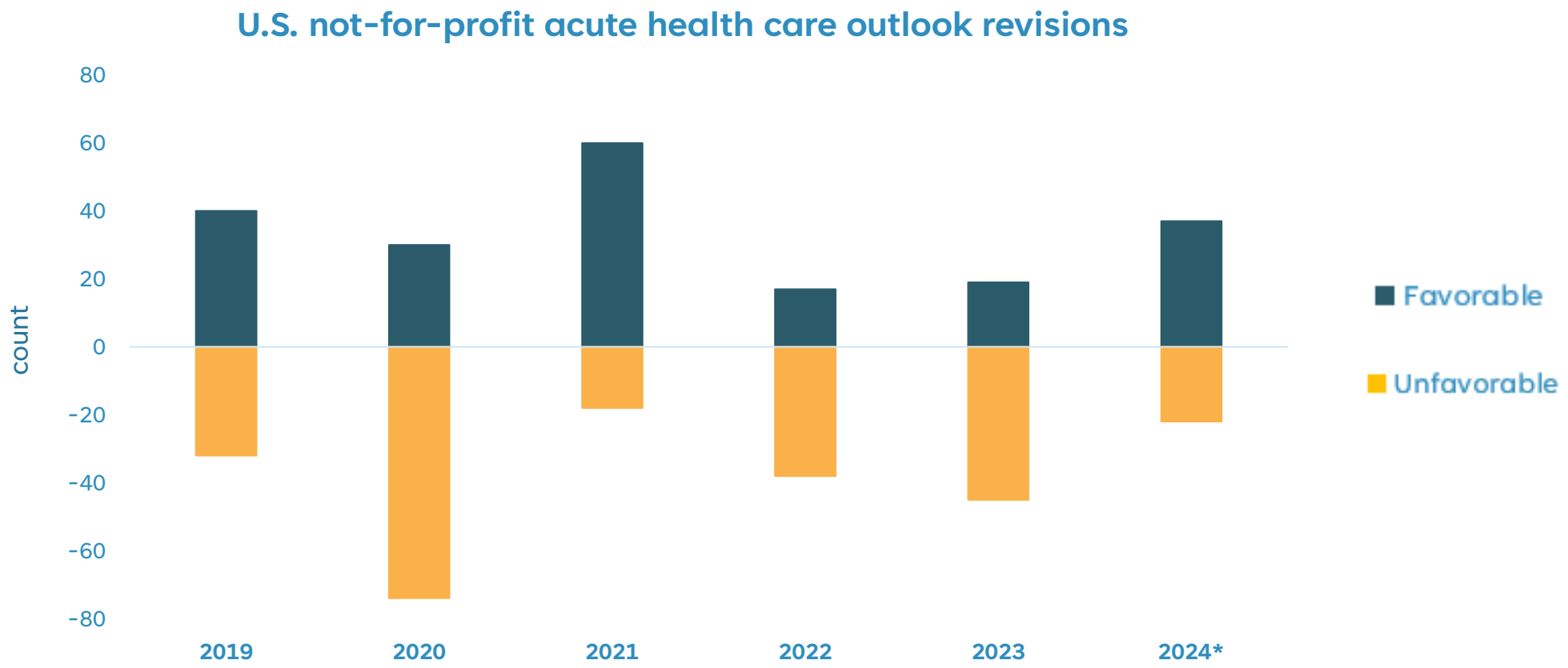
TIME IS NEVER A NEUTRAL FACTOR

When weighing strategic options, a rural hospital must weigh the pros and cons of the following timing factors:

- Time to demonstrate results from a performance improvement plan
- Time for major developments
- Time for adverse market developments to have an effect (state and federal budgets, competitor response, etc.)



2025 STATISTICAL ANALYSIS BASED ON 2024 DATA

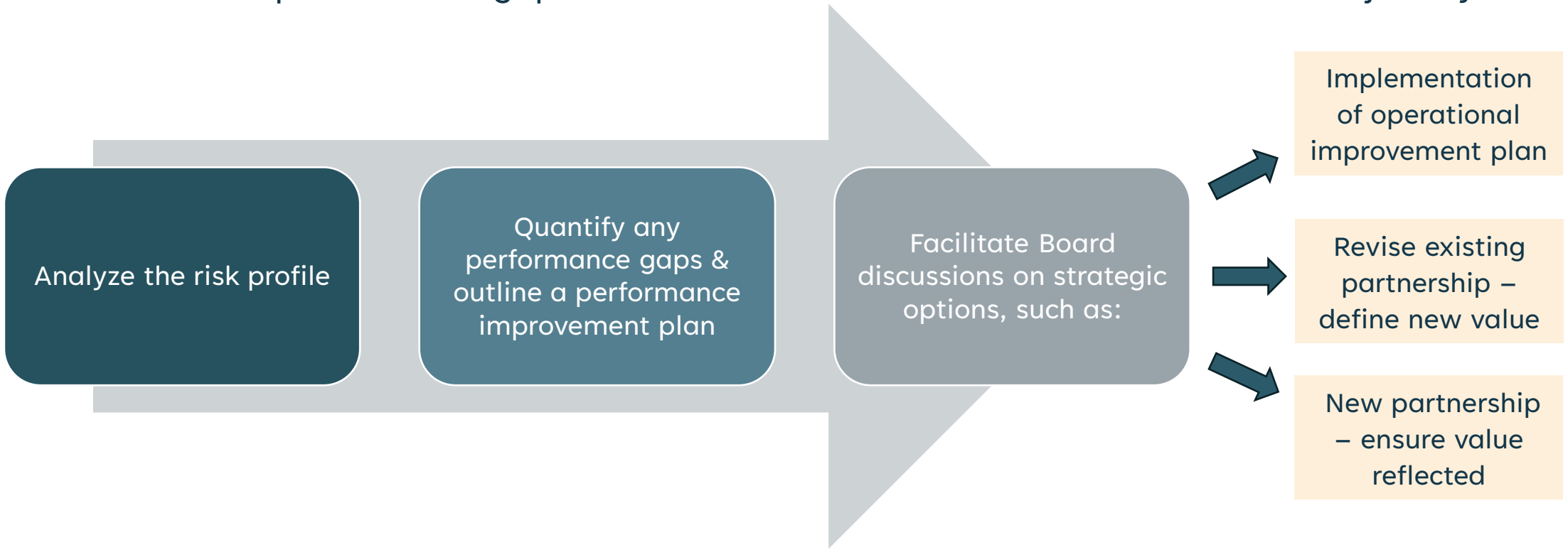


*Data as of Oct. 32, 2023. Data is for all outlook changes unaccompanied by a rating hange. Favorable outlook revisions include stable to postiive and negative to stable. Unfavorable outlook revisions include positive to stable and stable to negative. Excludes outlook revisions to developing and ratings that were removed from CredtWatch.

Source: S&P Global Ratings.

KEY POINT: OPERATING RESULTS AND STRATEGIC RISK

- Our focus is on mitigating strategic risks.
- Sound operating results are foundational to any strategic option.
- It is critical to understanding the organization's strategic risk profile, key risk trends and the extent of performance gaps between the current trend and a sustainable trajectory.



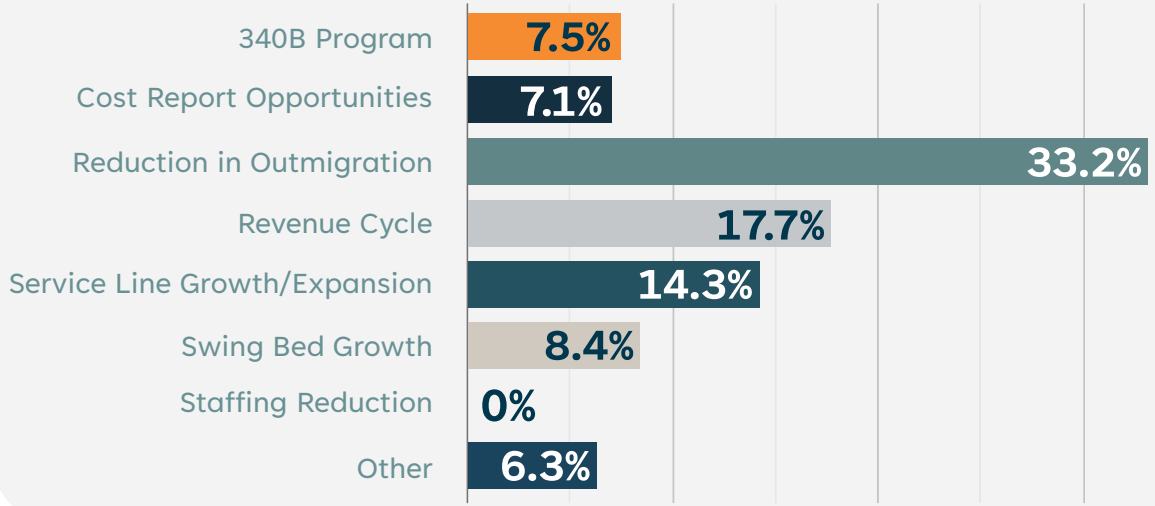
RISK MITIGATION VIA IMPROVED PERFORMANCE

- Nearly 30 rural performance improvement projects led by Stroudwater over a 30-month period delivered a median of $1.7M in financial improvement per organization, equating to nearly 8% of net patient revenue per organization.

Total Estimated Impact		
25th	$	1,300,000
Median	$	1,700,919
75th	$	3,727,000

Impact % of Net Pt Revenue	
25th	4.1%
Median	7.8%
75th	11.1%

- These engagements spanned an array of functional areas, with the average share of total improvement realized broken out as follows:



HOSPITAL CLOSURE OVERVIEW

GOALS OF HOSPITAL CLOSURE STUDY

Define & describe	Define & describe the glide path to rural hospital closure during the five years prior to closure
Strive	Strive to make the exposures of closure more understandable and actionable for rural hospital leadership
Provide	**Provide early warning framework for hospital leaders and boards of organizations**
Develop	Develop a framework for hospital boards to drive adoption of proactive steps to reduce hospital's overall strategic risk
Educate	Educate rural health systems regarding their organization's specific risk profile

KEY PROFILES OF HOSPITAL RISK

Financial performance

Operational methods

Value Indicators: Quality & Cost

Hospital characteristics

Market position

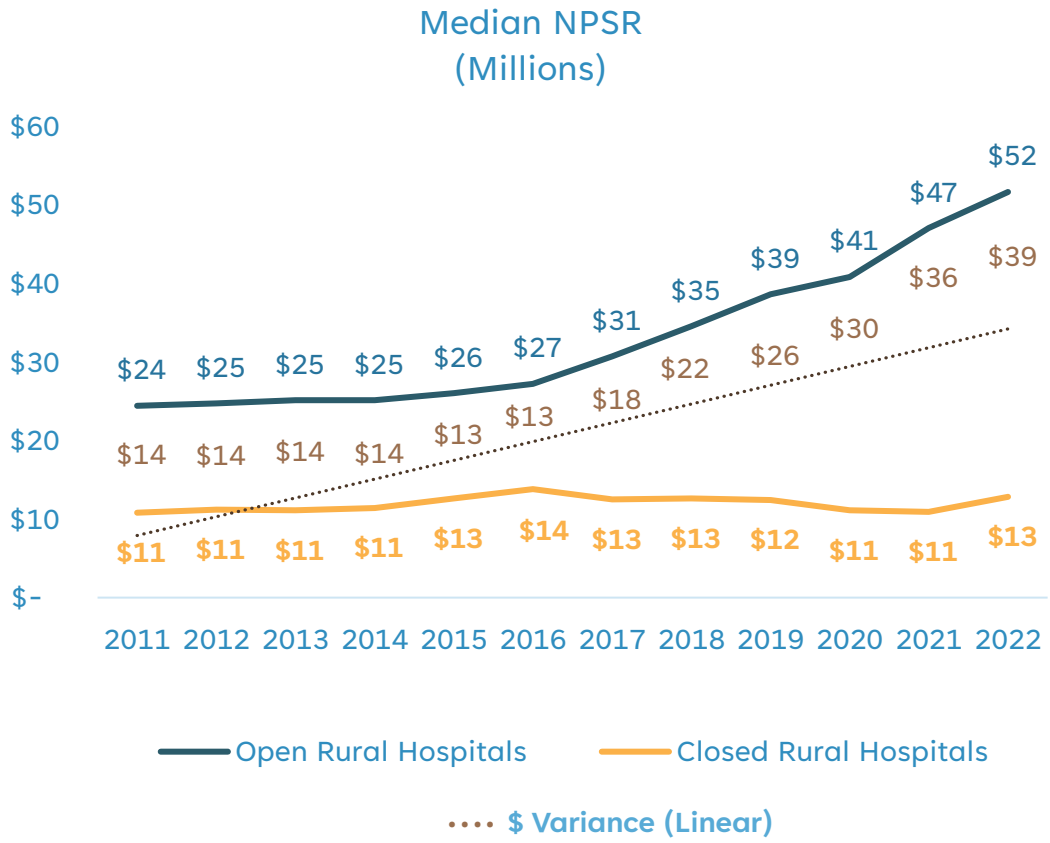
GROWTH TRAJECTORY OVERVIEW

Open vs. Closed Hospitals

OPEN RURAL HOSPITALS DEMONSTRATE SIZE & GROWTH DISPARITY

RURAL HOSPITALS

- The median net patient service revenue (NPSR) for open rural hospitals is more than 2 times the median NPSR for closed rural hospitals in 2011 and has grown to be 4 times the median NPSR of closed hospitals in 2022.
- Open rural hospitals reveal a significant increase in median NPSR from 2011 thru 2022 (7% CAGR), whereas closed hospital median NPSR shows minimal changes with a CAGR of 1.5%
- Hospital size – as measured by NPSR - was determined to be a factor that predicts the future risk for financial distress and closure in UNC closure studies*
- **Smaller size and the absence of growth are both foundational to the inherent lack of financial flexibility in rural hospitals**
- **Rural hospital growth supports long-term sustainability**



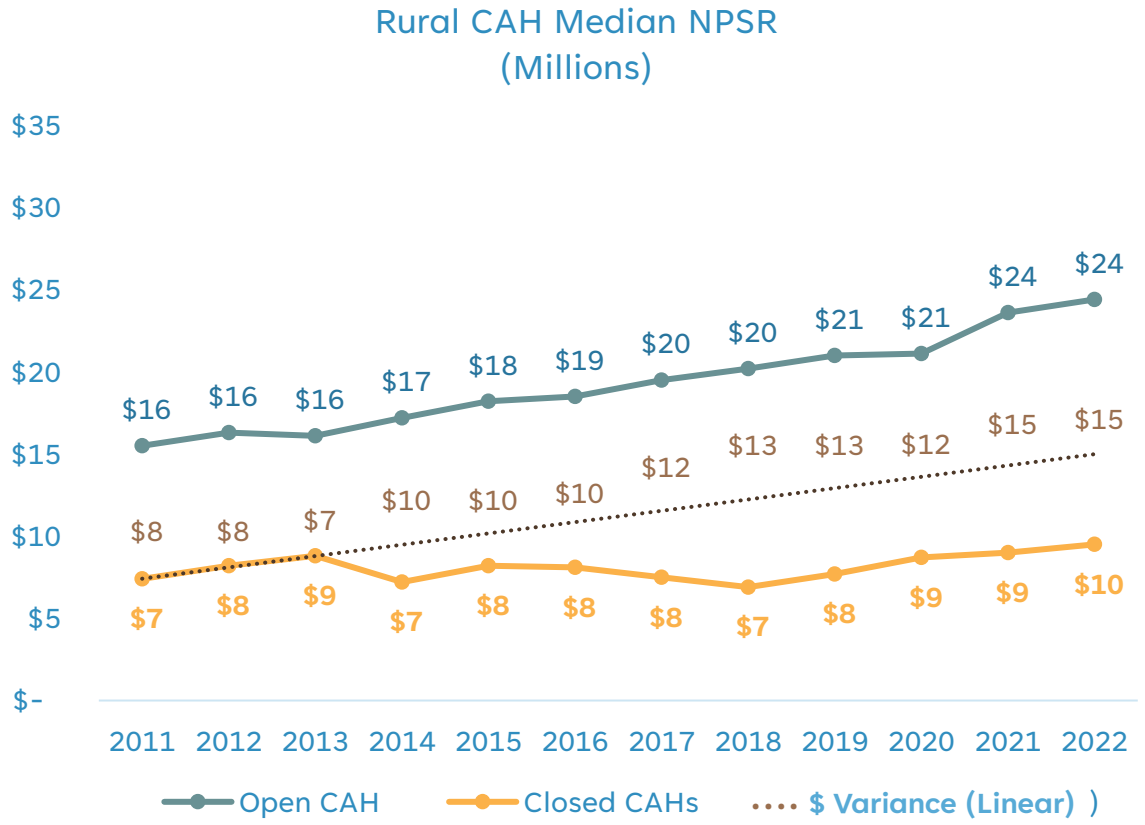
*North Carolina Rural Health Research Program/University of North Carolina (UNC) at Chapel Hill published 4 articles and/or findings brief from 2016 to 2024

Data source: HCRIS Medicare Cost Report data

OPEN RURAL CAH HAS STRONG GROWTH TRAJECTORY

RURAL CRITICAL ACCESS HOSPITALS

- The median net patient service revenue (NPSR) for open rural CAHs was between 2 times and 2.6 times the median NPSR of closed rural CAHs, or a difference of $7M to $14M per year
- **The median NPSR for closed rural CAHs increased at a compound annual growth rate (CAGR) of 2.3% from 2011 to 2022 compared to a CAGR of 4.2% for median NPSR at open rural CAH Hospitals**
- **The gap between the median NPSR for open CAHs vs. the median NPSR for closed CAHs increased by 56% from 2011 to 2022.**

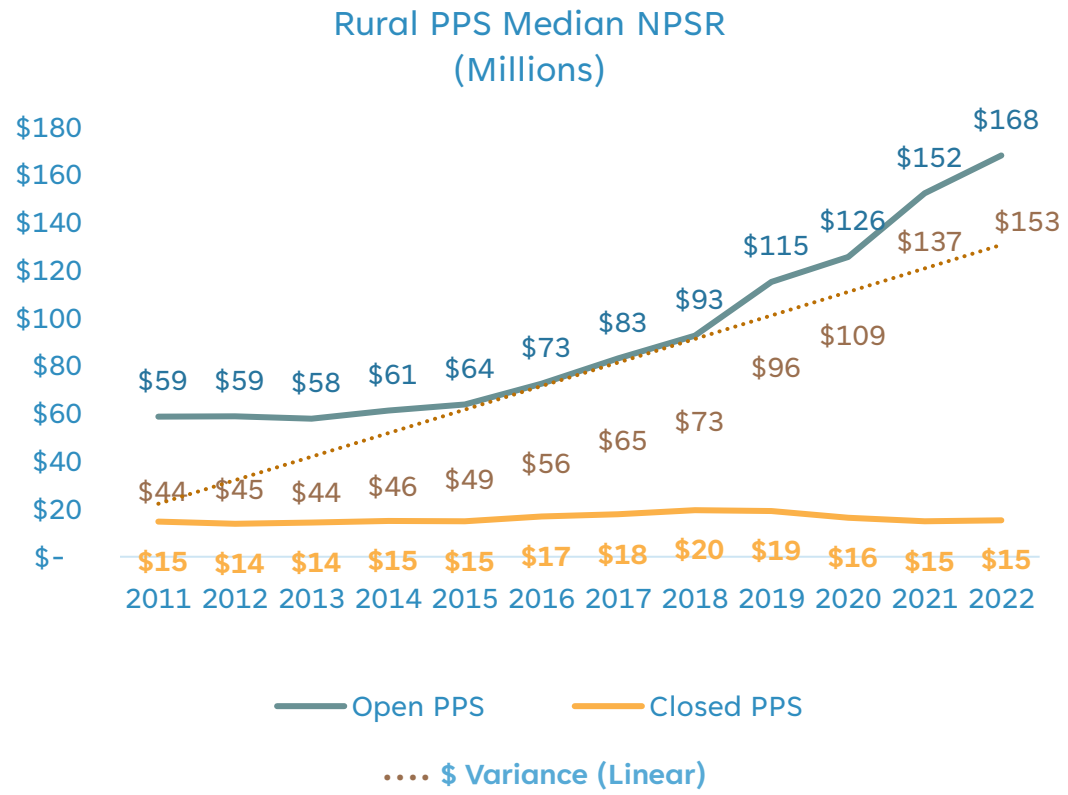


Data source: HCRIS Medicare Cost Report data

OPEN RURAL PPS HOSPITALS GREATER SIZE & GROWTH DISPARITY

RURAL PPS HOSPITALS

- The variance between median net patient service revenue (NPSR) for open and closed rural PPS hospitals increased substantially from 2011 to 2022
  - Median NPRSR for open rural PPS hospitals was 4 times that of closed rural PPS hospitals in 2011 and climbed to 11 times in 2022. The variance grew from $44M to $153M over that timeframe.
- **Median NPSR for closed rural PPS hospitals had a compound annual growth rate (CAGR) of .4% while the median NPSR for open rural PPS hospital had a CAGR of 10% for 2011 to 2022**

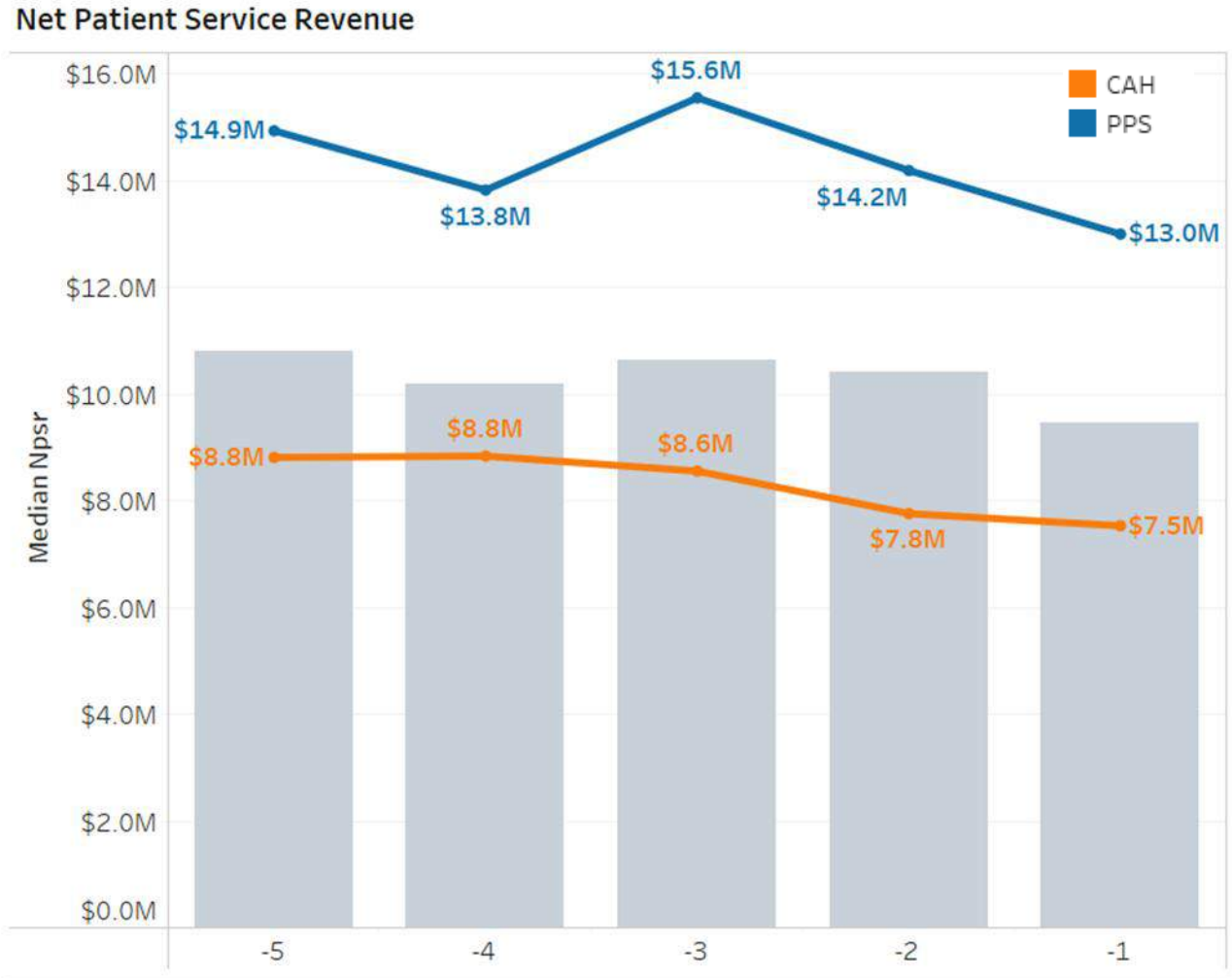


Data source: HCRIS Medicare Cost Report data

JOURNEY TO HOSPITAL CLOSURE: NO REVENUE GROWTH

CLOSED RURAL HOSPITALS

- Median net patient service revenue (NPSR) for all closed rural hospitals declined by 12% in the 5 years before rural hospital closure.
  - This trend produces a CAGR of -2.9% in the five years prior to closure.
- The Median NPSR for closed Rural PPS hospitals declined by 12.6% in the five years before closure.
  - This trend produces a CAGR of -3.0% in the five years prior to closure.
- Median NPSR for closed Rural CAHs decreased by 14.8% with a CAGR of -3.5% in the five years before closure.
- **The absence of revenue growth is an indicator of closure risk**



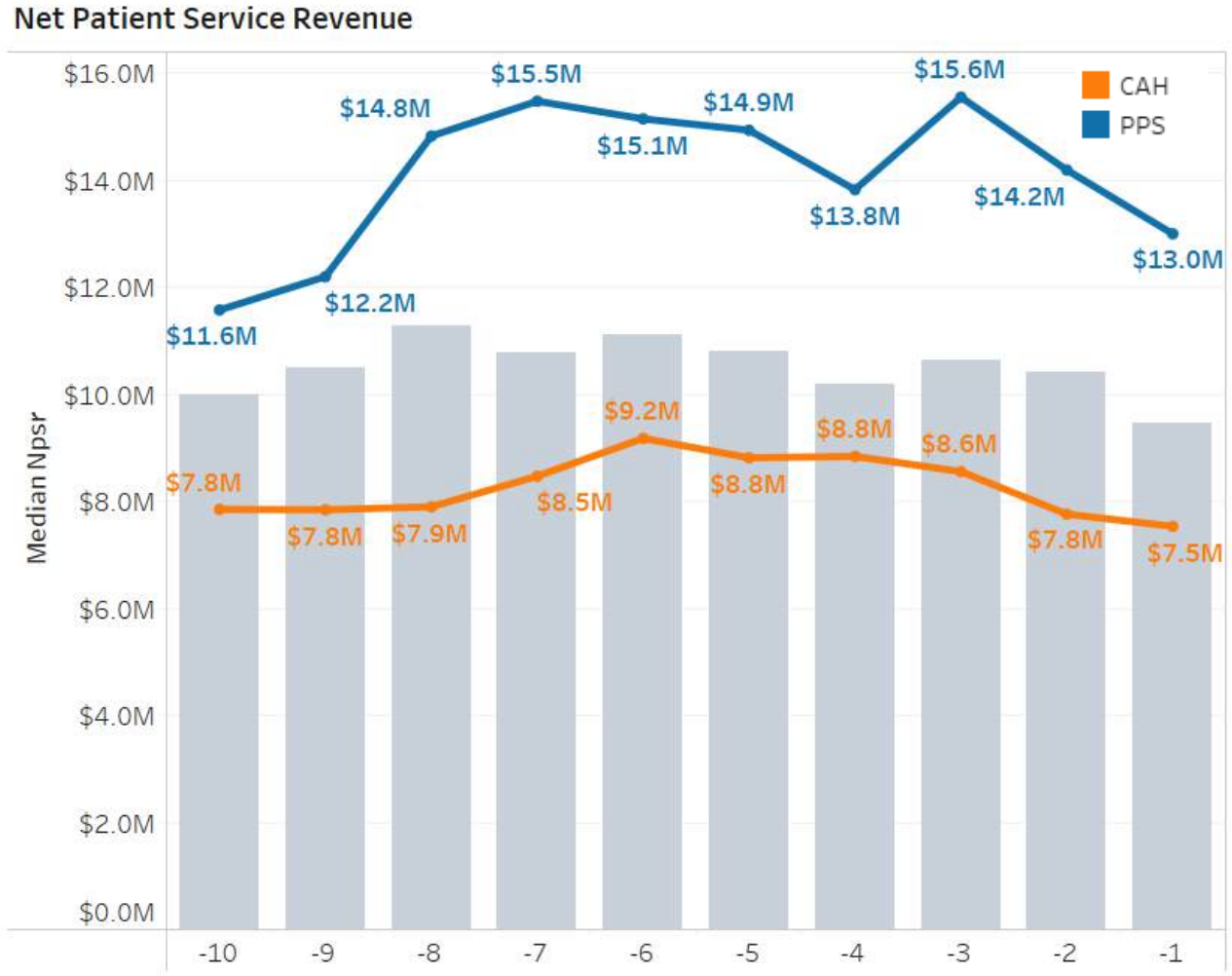
	-5	-4	-3	-2	-1
Median	$10.8M	$10.2M	$10.6M	$10.4M	$9.5M
Observations	144	149	162	169	152

Data source: HCRIS Medicare Cost Report data

JOURNEY TO HOSPITAL CLOSURE: 10 YEARS PRIOR

CLOSED RURAL HOSPITALS

- Median net patient service revenue (NPSR) for all rural closed hospitals declined by 5% in the 10 years prior to closure.
- Median NPSR for all closed rural hospitals increased 11% between 10 and 6 years prior to closure for a CAGR of 2.9%.
- In contrast, median NPSR for all closed rural hospitals during the five years prior to closure declined by 12% with a CAGR of -2.9%.
- **The absence of sustained growth over the 10 years prior to closure – with a marked fall-off in the five years prior to closure - affirms flat or declining top line revenue as an indicator of closure risk.**



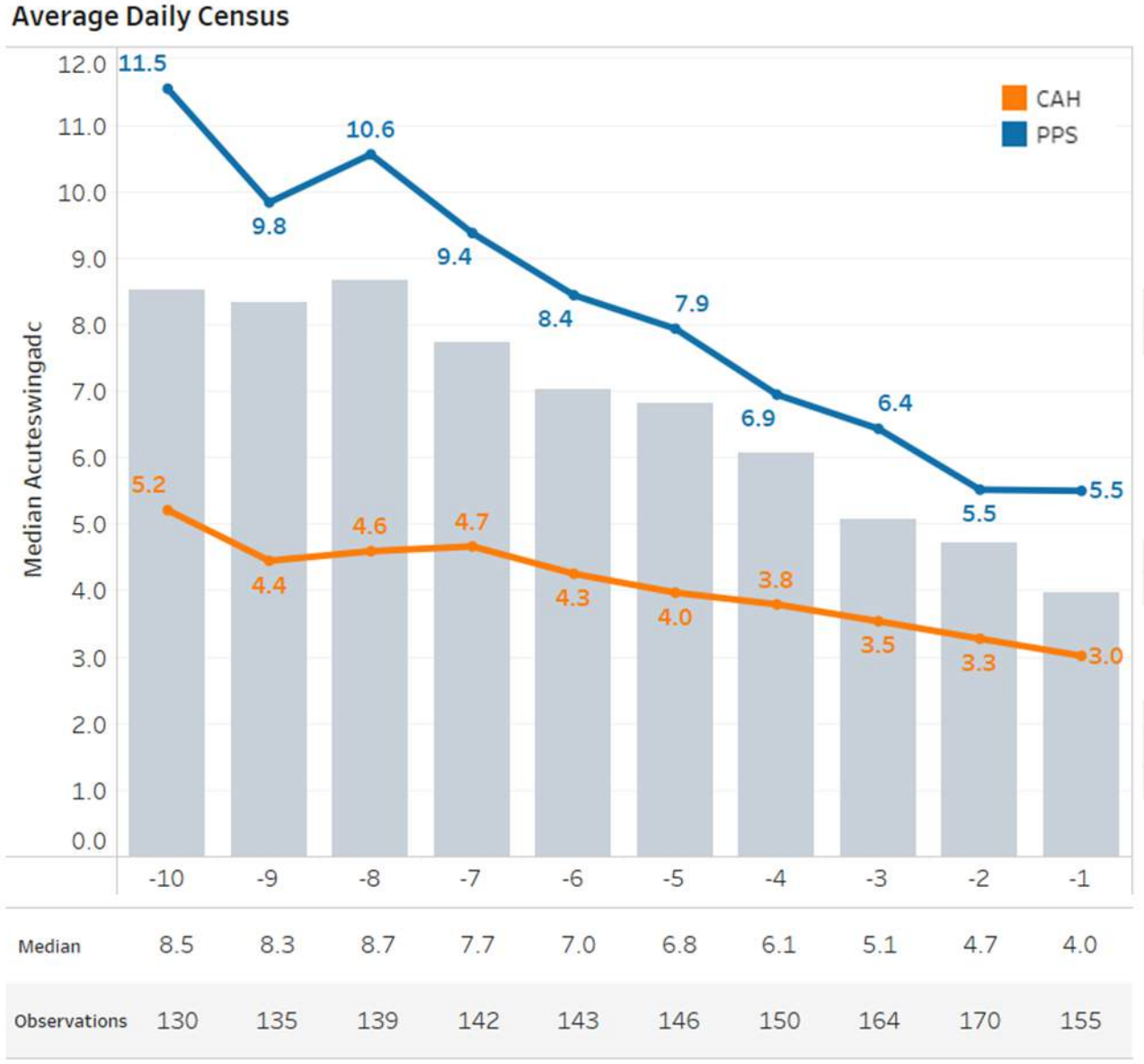
	-10	-9	-8	-7	-6	-5	-4	-3	-2	-1
Median	$10.0M	$10.5M	$11.3M	$10.8M	$11.1M	$10.8M	$10.2M	$10.6M	$10.4M	$9.5M
Observations	128	134	137	141	143	144	149	162	169	152

Data source: HCRIS Medicare Cost Report data

ADC DOWNWARD PATH BEGINS 10 YEARS PRIOR TO CLOSURE

CLOSED RURAL HOSPITALS

- Median average daily census (ADC) for all closed rural hospitals decreased by 53% over the 10 years prior to closure.
- For all closed rural hospitals, median ADC declined by 18% between years 10 and 6 prior to hospital closure and by 41% between 5 to 1 years prior to closure (inclusive of swing bed programs).
- **Steady declines in inpatient census is a risk indicator for hospital closure**



Data source: HCRIS Medicare Cost Report data

RELATIVE SIZE & GROWTH ARE IMPORTANT

SUMMARIZED

- Median revenue size varies amongst closed rural hospitals between $10M and $15M annually, with a substantial variance in Open PPS hospital revenue of nearly 7 times that of open CAHs
- Annual revenue growth for open hospitals is 5.5 percentage points higher than for closed hospitals
- Average daily census (ADC) declined for all hospitals except open rural PPS hospitals and declined less for open rural CAH hospitals compared to closed rural CAH hospitals
- **ADC Compound Annual Growth Rate (CAGR) declined for closed rural hospitals at substantially higher rates than open rural hospitals**

Metric	All Open Rural Hospitals	All Closed Rural Hospitals	Open Rural CAH	Closed Rural CAH	Open Rural PPS	Closed Rural PPS
2022 Median NPSR	$52M	$13M	$24M	$10M	$168M	$15M
2011 to 2022 Median NPSR CAGR	**7.0%**	**1.5%**	**4.2%**	**2.3%**	**10.0%**	**0.4%**
2022 Median ADC	9.4	3.2	4.9	2.3	44.9	4.9
2011 to 2022 Median ADC CAGR	**-0.4%**	**-7.1%**	**-1.9%**	**-4.5%**	**6.1%**	**-6.0%**

Data source: HCRIS Medicare Cost Report data

POLLING QUESTION

How significant is the risk that your hospital may need to convert or close within the next 36 months or more?

a. Very likely
b. Somewhat likely
c. Unsure
b. Somewhat unlikely
c. Not at all likely

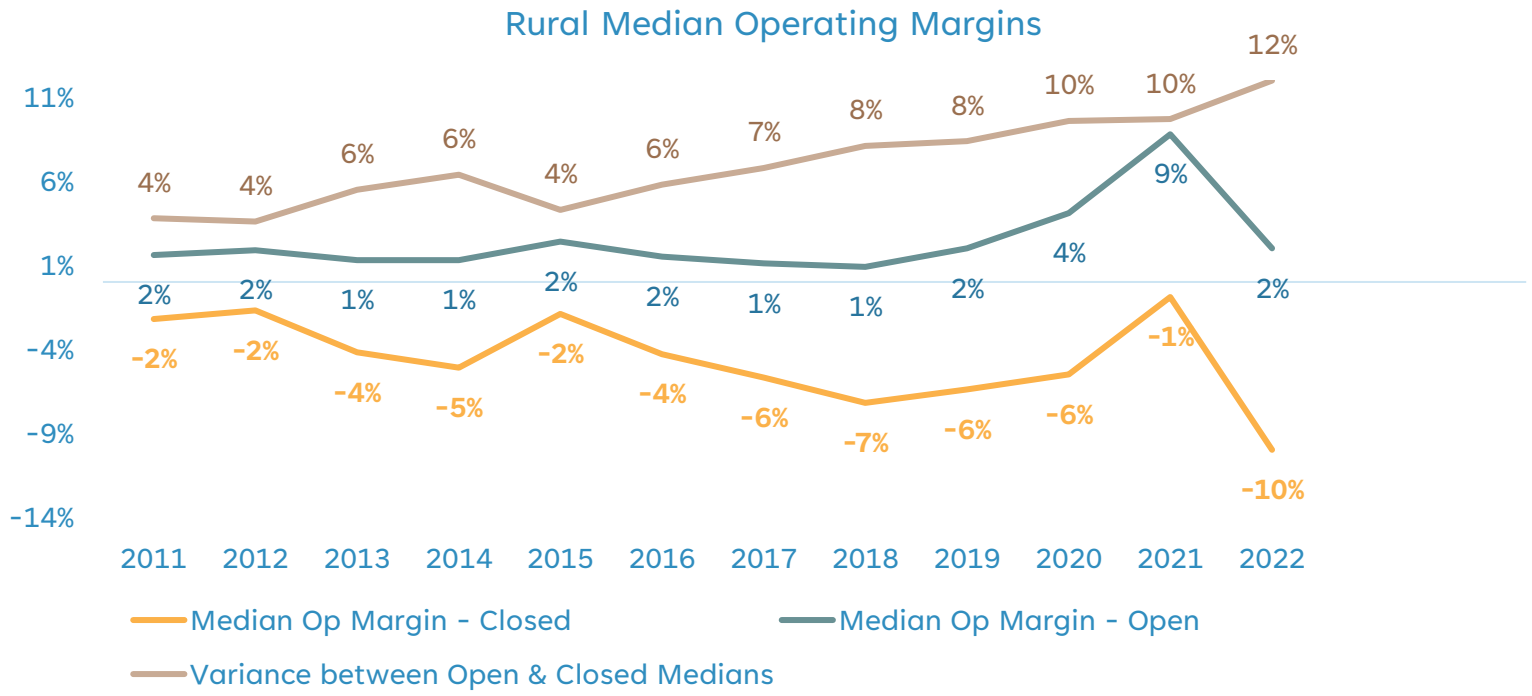
FINANCIAL TRAJECTORY OVERVIEW

Open vs. Closed hospitals

OPERATING MARGINS LOOM NEGATIVE FOR YEARS WITH INCREASED VARIATION

CLOSED & OPEN RURAL HOSPITALS

- Closed rural hospitals have stronger fluctuations in operating margin than hospitals that have remained open.
- Closed rural hospitals have rarely achieved positive margins over the measured period. Closed hospitals reveal financial challenges that existed before COVID, which are now beginning to find their new post-COVID normal.
- **Closed hospitals consistently struggle to produce cash from operations, leading to cash flow and reinvestment challenges. Generating funding from healthcare operations is foundational to long-term financial success.**

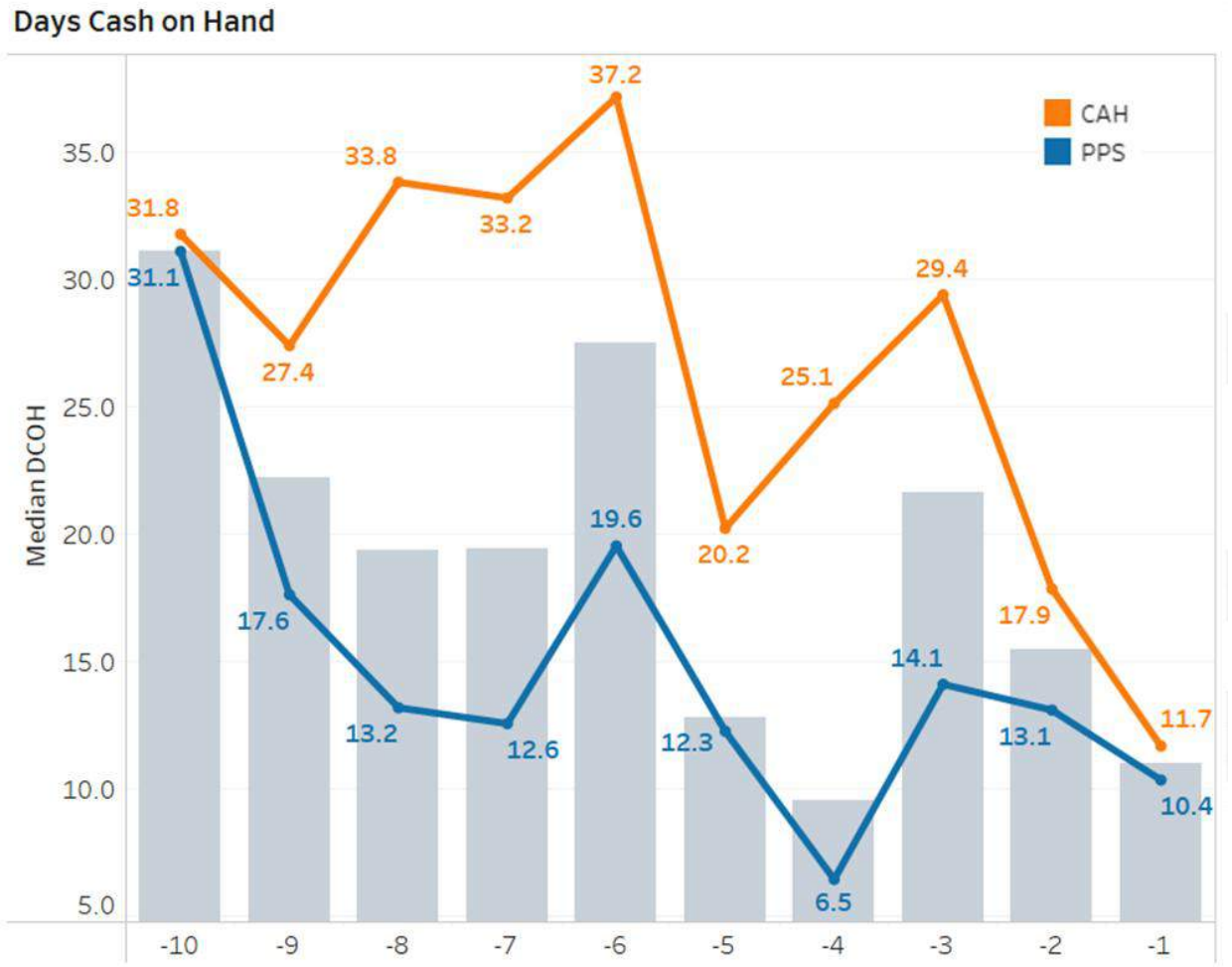


Data source: HCRIS Medicare Cost Report data

CLOSED RURAL HOSPITALS: LIQUIDITY CONCERNS 5 TO 7 YEARS PRIOR TO CLOSING

CLOSED **INDEPENDENT** RURAL HOSP

- Only independent or non-system-affiliated hospitals were analyzed for DCOH due to the impact of health system subsidiary cash sweep policies
- Median DCOH overall declined 65% over the ten years before hospital closure
- Closed CAH hospitals had consistently higher levels of DCOH than PPS hospitals. However, this gap narrowed in the final two years prior to closure.
- Closed independent rural PPS hospitals saw a quick decline in median DCOH as early as 9 years before closure, as compared to closed independent CAH hospitals who maintained DCOH through year -6.
- **PPS hospitals declined 51% in years six to ten before closure and dropped only 15% in the five years prior to closure.**
- **Closed independent rural CAH hospitals saw the most significant decline three years before closure**

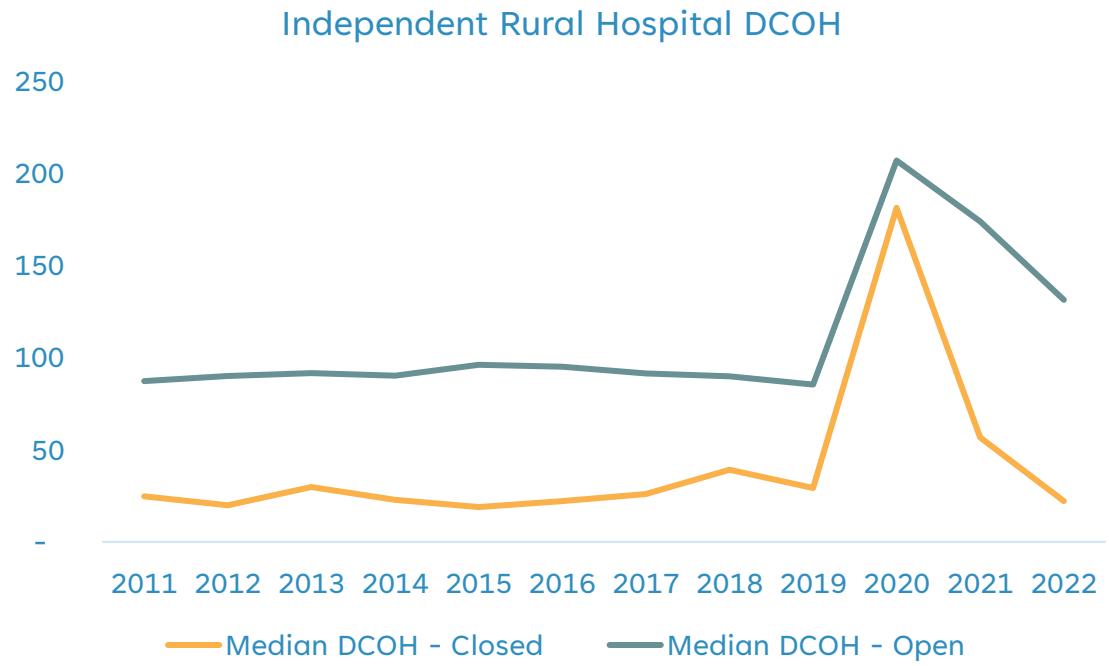


Data source: HCRIS Medicare Cost Report data

CLOSED RURAL HOSPITALS CASH MORE UNPREDICTABLE

INDEPENDENT RURAL HOSPITALS

- Open rural hospitals show less volatility in DCOH than closed hospitals
- Both open and closed rural hospitals saw significant liquidity gains in 2020 that eroded in the two following years
- **Overall, closed rural independent hospitals had similar overall trends to open rural hospitals, however, closed hospitals ran with DCOH significantly lower than hospitals that remained open**



Data source: HCRIS Medicare Cost Report data

*Source: CAH Financial Indicators Report for 2022, Flex Monitoring Team, April 2024

OPERATIONAL & FINANCIAL PERFORMANCE

SUMMARIZED

- Median operating margins (Op Margin) are consistently negative for closed hospitals with a substantial declining compound annual change rate
- Median Days Cash on Hand (DCOH) for closed rural hospitals is below open hospitals overall and substantially lower than open CAHs and the national average for CAHs
- **Benchmarking financial performance provides valuable insights relating to the financial risks of hospital closure**

Metric	All Open Rural Hospitals	All Closed Rural Hospitals	2022 Open Rural CAH Hospital Benchmark *	Open Rural CAH	Closed Rural CAH	Open Rural PPS	Closed Rural PPS
2022 Op Margin	2%	-10%	3%	3%	-5%	1%	-11%
2022 Op Margin CAGR	2%	-15%	--	11%	-13%	-10%	-15%
2022 DCOH	131	22	126	159	30	93	17

Data source: HCRIS Medicare Cost Report data

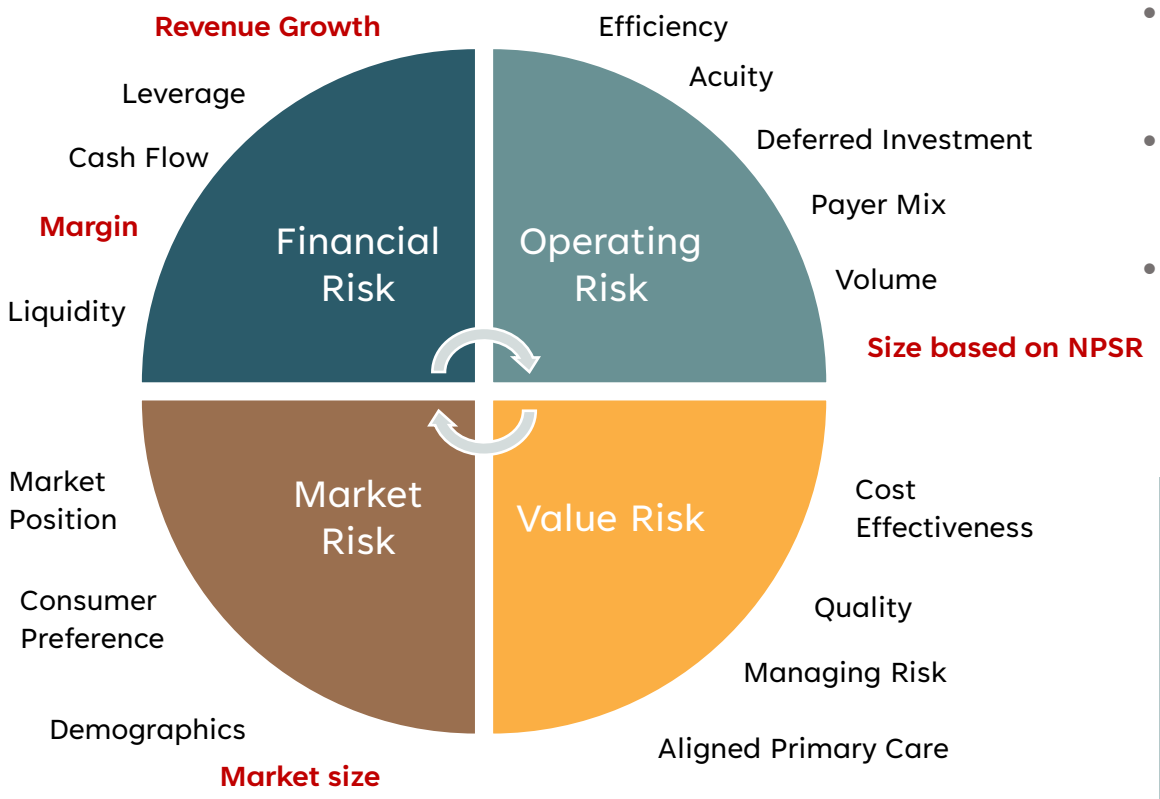
*Source: CAH Financial Indicators Report for 2022, Flex Monitoring Team, April 2024

NEXT STEPS – EFFECT OF HOSPITAL CHARACTERISTICS

- Determine what other key variables within the risk of closure are definable differentiators, such as:
    - Analysis normalized by year of closure
    - Additional financial indicators
    - Additional value indicators
    - **Operational Performance**
    - **Market position**
    - **Environmental dynamics**

STRATEGIC RISK ANALYSIS

FACTORS THAT AFFECT RISK



- The four risk domains depicted to the left describe the major sources of strategic risk in today's environment
- Poor performance in one domain will have collateral or "spillover" effects on one or more of the other domains
- Key trends within each risk category should be monitored annually, and long-term trends should be quantified. Over time, the cumulative impacts can be very significant.

Boards may not appreciate the cumulative effects of changes in risk factors that can take place over several years.

POLLING QUESTION

- How confident are you that your Board truly “gets” your organizations strategic risk profile?

  a. Very confident – they’re well versed and proactive; this is part of their annual planning

  b. Fairly confident – they understand the basics but may not review key factors on a scheduled basis

  c. Not at all confident – limited engagement with risk; no evidence of regular board reviews/discussion of organization risk profile

  d. Totally lacking – board has no understanding of risk factors and never reviews or discusses changes to organization’s risk profile

  e. Not applicable – do not have a board

KEY TAKEAWAYS

THE KEY LESSONS LEARNED FROM HOSPITAL CLOSURES

OPERATIONAL PERFORMANCE IS FOUNDATIONAL TO ANY STRATEGIC OPTION

TIME IS NEVER A NEUTRAL FACTOR; AT A MINIMUM, TWO YEARS IS NEEDED TO EXECUTE A TURN AROUND

KNOW YOUR VALUE AND RISK PROFILE; DO THE HOMEWORK

THERE ARE NO RISK-FREE STRATEGIC OPTIONS

EARLY ACTION SAVES HOSPITALS; THE SOONER YOU ALTER COURSE, THE LESS DRASTIC THE COURSE CORRECTION REQUIRED

Thank You

Jeffrey Sommer, Managing Director
▪ jsommer@stroudwater.com ▪
207.221.8255

Julie Georgoff, Consultant
▪ jgeorgoff@stroudwater.com ▪
207.221.8273

1685 Congress St. Suite 202

Portland, Maine 04102

www.stroudwater.com